echocare
SPECIALTY PHARMACY
"Your partner in patient care"

260 Broadway
Brooklyn, NY 11211
Phone: 718-782-0101
Fax: 718-782-2626
www.EchoDrugs.net

HEPATITIS C REFERRAL FORM

Fax prescription to: 718-782-2626

Faxed prescriptions can only be accepted from prescribing practitioners

Date Needed By _____ Ship to: ☐Patient ☐Office ☐Other: _____

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ SS# _____ DOB _____

☐Male ☐Female Height_____ Weight _____ Age _____

Allergies _____ ☐NKDA

INSURANCE INFORMATION

Please attach front and back of all insurance and prescription drug cards

PRESCRIBER INFORMATION

Name _____

NPI _____ State License# _____

Group/Hospital _____

Address _____

City, State, Zip _____

Main Phone _____ Fax _____

Contact Person _____ Phone _____

CLINICAL EVALUATION

DIAGNOSIS

☐ Chronic Hepatitis C (B18.2)
☐ Acute Hepatitis C (B17.1)
☐ Liver Transplant (Z94.4)
☐ HIV (B20)
☐ Other _____

Diagnosis Date _____

Please include a copy of lab reports, fibroscore,. biopsy report, progress notes, clinical data, and current vital signs. Fax to: 718-782-2626

LABS

HCV Genotype _____ Weight _____ Fibrosis Score _____ Viral Load _____ Lab Date _____

PREVIOUS THERAPIES

☐ Ribavirin + Peg Interferon
☐ Ribavirin + Peg Interferon + Other _____
☐ Other _____
☐ Dates of Therapy_____

Previous Therapy Outcome

☐Naive ☐Partial ☐Non-Responder ☐Relapser ☐Other_____

PATIENT HAS: (check all that apply)

☐ Coinfection of HBV
☐ Autoimmune Hepatitis
☐ Co-infection of HIV
☐ Cirrhosis (Compensated)
☐ Cirrhosis (Decompensated)

Does patient have a history of solid organ transplant or is patient a candidate for transplant?
☐Yes ☐No

Has patient previously failed therapy with a treatment regimen that includes a protease inhibitor?
☐Yes ☐No

If taking Ribavirin, is patient or partner pregnant or unwilling to use adequate contraception?
☐Yes ☐No

PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & DIRECTIONS	QUANTITY	DURATION	REFILLS
☐ **EPCLUSA (velpatasvir/sofosbuvir)**	☐ 100mg/400mg - Take by mouth once daily	☐ 28 x 100mg/400mg ☐ Other _____	☐ 12 Weeks ☐ 24 Weeks	
☐ **HARVONI (ledipasvir/sofosbuvir)**	☐ 90mg/400mg - Take by mouth once daily	☐ 28 x 90mg/400mg ☐ Other _____	☐ 8 Weeks ☐ 12 Weeks ☐ 24 Weeks	
☐ **MAVYRET (glecaprevir and pibrentasvir)**	☐ 100mg/40mg - Take 3 tablets by mouth once daily with food	☐ 28 x 90mg/400mg	☐ 28 Days	
☐ **RIBAVIRIN TABLET** ☐ **RIBAVIRIN CAPSULE** ☐ **OTHER** _____	☐ Take _____ by mouth in the **morning** and by mouth in the **evening** ☐ Other _____	☐ ____ x 200mg ☐ Other _____	☐ 12 Weeks ☐ 24 Weeks ☐ Other _____	
☐ **TECHNIVIE (ombitasvir/paritaprevir/ritonavir)**	☐ 12.5mg/75mg/50mg - Take by mouth **twice** daily	☐ 56 x 12.5/75/50mg ☐ Other _____	☐ 12 Weeks ☐ Other _____	
☐ **VIEKIRA XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)**	☐ 200/8.33/50/33.33mg - Take 3 by mouth **once** daily with food	☐ 84 tablets	☐ 12 Weeks ☐ 24 Weeks ☐ Other _____	
☐ **ZEPATIER (elbasvir/grazoprevir)**	☐ 50mg/100mg - Take by mouth once daily	☐ 28 x 50mg/100mg	☐ 12 Weeks ☐ 16 Weeks	
☐ **OTHER** _____				

By signing this form and utilizing our services, you are authorizing Echo Care Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature _____ ☐DAW Date _____